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LEADERSHIP PAGE

A Micro View of MACRA

How the ACC and NCDR Will Help Members Navigate Radical Changes Ahead

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"If you're not at the table, you're on the menu."
—Michael Enzi (1)

Most of us used to think of the transformation from volume- to value-based purchasing of health care as "5 years away and always will be." This is certainly no longer the case. At our recent Legislative Conference, our attending American College of Cardiology (ACC) membership was initially surprised at, and then totally engaged in and galvanized by, our discussions outlining the sea change that is occurring in Medicare payment policy. The way we practice will change, and the change will come quickly. Although all of the parameters have not been finalized, the framework is up, the stakes are high, and the time is short.

The Medicare and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015, after more than a decade of collaboration by medical societies and members of Congress to find a permanent solution to repeal the flawed sustainable growth-rate formula.

Passage of this historic law continues to move the United States toward a health care system that is focused on quality and value versus the current volume-based fee-for-service model. Earlier this year, the U.S. Department of Health and Human Services (HHS) set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 through programs such as the Hospital Value-Based Purchasing Program and the Hospital Readmissions Reduction Program, and 30% of payments to alternative payment models (APMs) such as accountable care organizations or bundled payments in the same time frame (2).

Although a lot of work and unanswered questions remain in terms of implementation, MACRA does remove what had become continuous uncertainty around Medicare physician payment and implements stable payment increases starting this year. It also streamlines Medicare quality reporting programs and builds incentives for APM participation into the payment system itself.

Specifically, MACRA takes a 2-pronged approach to payment: clinicians will be able to choose whether to participate in the Merit-Based Incentive Payment System (MIPS) or APMs beginning in 2019. MIPS will replace the current Physician Quality Reporting System, the Value-based Payment Modifier, and the Medicare Electronic Health Record (EHR) incentive programs with a single, consolidated program consisting of quality, resource use, meaningful use of certified EHR technology, and a new category of participation in clinical practice improvement activities. This new category will provide credit to clinicians for participating in activities such as expanding practice hours, using surgical checklists, and reporting to clinical data registries. APM participation—the second MACRA payment pathway—will exempt "qualifying APM participants" from MIPS reporting requirements and payment adjustments and will instead provide a lump-sum incentive payment equal

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to 5% of the prior year's estimated aggregate expenditures under the fee schedule. This 5% incentive payment will be available from 2019 to 2024. Additionally, beginning in 2026, the annual fee schedule growth rate will be higher for qualifying APM participants than for other practitioners. Of particular note to cardiology, MACRA encourages expansion of APM options available to physicians, especially specialists, through physician-focused payment models. This is a valuable opportunity for stakeholders, such as the ACC, to participate in the development and testing of new models. (In fact, Dr. Casale was appointed by the Government Accountability Office to the Physician-Focused Payment Model Technical Advisory Committee, which was established by MACRA to provide comments and recommendations to the HHS secretary on physician payment models. The ACC nominated him to serve on this committee.)

The specifics of both of these pathways will be defined over the next 8 months. MACRA requires that the HHS develop and publish a draft plan for MIPS and APM measure development by January 2016, with a final plan expected in May 2016. The good news is that HHS is reaching out to stakeholders for their feedback throughout the implementation process. Most recently, the Centers for Medicare & Medicaid Services (CMS) issued a formal request for information seeking public comments on how to implement MACRA. It is encouraging to see that CMS recognizes the breadth of potential changes under MACRA. Rather than going straight through the formal rulemaking process, CMS instead chose to first issue a list of 127 questions, allowing stakeholders to help define MACRA implementation before the agency issues any policies. The request for information seeks recommendations through questions such as how many clinical quality measures should clinicians report, how should resource use measures align with clinical quality measures, what type of feedback is most valuable to clinicians for assessing performance and improvement, and how should a "physician-focused payment model" be defined? Other questions address the technical aspects of quality reporting, such as how to ensure the integrity of registry-reported data and the processes for collecting data on each of the MIPS composite categories.

Answering these questions, along with the many others that will likely arise as implementation moves forward, is a top priority for ACC leaders and staff. This is our opportunity to be innovative and think beyond the current payment system to propose ideas for what could work and provide input about what has not worked in the past. We are also working to make sure members are more broadly educated about MACRA and are equipped to participate going forward. To date, we have held webinars, created online issue briefings under the advocacy section of ACC.org, attended chapter meetings across the country, and even took our messages to Capitol Hill as part of our annual Legislative Conference in October. We will be continuously updating a library of educational materials about MACRA on ACC.org for easy access by members.

What can you do going forward, and how can you be prepared for the changes ahead? First, recognize that participation in current programs is the best preparation for future programs. Practice quality improvement efforts, quality reporting, and value-based reimbursement are here to stay, and will undoubtedly be a critical part of provider payment models regardless of how the details of MIPS and APMs unfold. In fact, the long-term strategic vision of CMS for quality reporting programs includes the use of feedback and data to drive rapid-cycle quality improvement; public reporting of meaningful, transparent, and actionable information; aligned measure portfolio; and aligned reporting and value-based purchasing program policies (3).

Clinicians already participating in the EHR Incentive, Physician Quality Reporting System, and Value-Based Modifier are arguably ahead of the game as MACRA moves to align these programs. Involvement in National Cardiovascular Data Registry (NCDR) registries, like the ACC's free, outpatient PINNACLE registry, can also help. For example, clinicians currently participating in the registry can choose to have the ACC submit Physician Quality Reporting System data to CMS on their behalf and can use the registry's monthly feedback reports to monitor and improve performance before final data is submitted to CMS at the end of the year. Additional opportunities and practice improvement programs are under development at the ACC to leverage both hospital and outpatient registries to make it easier for the 21,881 unique providers participating in the NCDR to engage with MACRA. The time is now for all ACC members to be certain that they are participants in at least 1 of the NCDR registry programs and to become familiar with their NCDR data.

Other projects that will prepare ACC members for the new landscape under MACRA are also in the works. For example, the College is currently participating in the Core Quality Measure Collaborative convened by CMS and America's Health Insurance Plans to develop core measure sets for use in federal and commercial programs and potentially APMs, including a cardiology measure set. These core measures, which will align with the triple aim of better care, better outcomes, and lower costs, will be

phased in starting with the specialties of groups, like the ACC, that are involved in the initial development. Additionally, many of these Core Quality measures can be measured by the ACC's NCDR. According to CMS, this phase-in approach will allow payers to evaluate the timing of adoption of these core measures through the procedures used in their programs and contracts over time.

When laying out plan for the future of the HHS, HHS Secretary Sylvia Burwell noted: "Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people" (1). No one ever said that change was easy, but after a decade-long battle to move toward a new health care system that rewards quality and outcomes, we have an opportunity and an obligation to make the most out of MACRA. Collectively, we can facilitate change and transform not just cardiovascular care, but health care as a whole.

The ACC leadership and staff are committed to helping define how these measures are implemented and how new payment programs are designed, aiming to preserve access to high-quality care in our cardiovascular service lines. We will do a deep dive into these developments during the 2016 Cardiovascular Summit: Solutions for Thriving in a Time of Change in Las Vegas, Nevada, this February 2016 (http://www.ACC.org/cvsummit16). We will also continue to communicate the initiatives under consideration, and we welcome your involvement and your feedback.

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